

Proposed standards for Canadian endoscopy units in the '90s

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BOTH HOSPITALS AND GOVERNMENTS ARE TAKING IN-creasingly closer looks at the practice of endoscopy (1). With a specified amount of money allotted each year for medical and hospital budgets, these and other well defined units are more readily subject to medical audit, quality of care evaluations and, with increasing emphasis on outpatient procedures, cost benefit analysis. The standards of care cannot be imposed by national organizations (2,3) such as the Canadian Association of Gastroenterology; instead each unit is subject to the hospital accreditation committee, which may contain an endoscopy review committee. The following suggested standards are easily attainable, and if adhered to by all, should create more uniform, high quality units across the country.

- All patients undergoing endoscopy should be seen, interviewed and examined by the endoscopist prior to the procedure.
- Pre- and post endoscopy vital signs should be recorded.

- In selected patients with cardiorespiratory disease or cardiovascular instability (eg, gastrointestinal bleeding), vital signs, ECG and pulse oximetry should be monitored during the procedure.
- Continuous intravenous access is mandatory in patients with cardiorespiratory disease or cardiovascular instability, and is preferable in all others.
- Cardiopulmonary resuscitation equipment should be readily available and the pertinent drugs regularly checked and kept up-to-date.
- A recovery room is essential, with registered nursing personnel in continuous attendance. Wall-suction and oxygen should be available.
- In view of the fact that the infectious status of the patient is not known in every case, universal precautions whereby all blood and secretions are regarded as infectious should be in place.
- Meticulous physical cleansing of the endoscope is the most important part of the sterilization procedure, and should be

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performed in all cases prior to 10 min sterile soaks or gas sterilization. This procedure is greatly assisted by the exclusive use of immersible endoscopes.

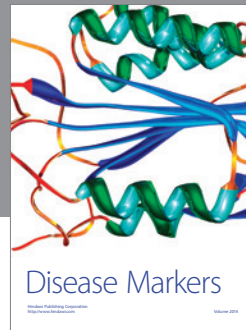
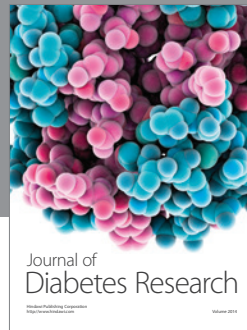
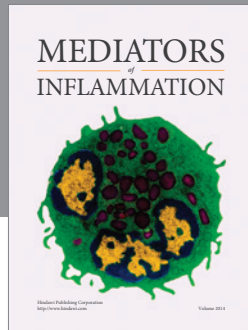
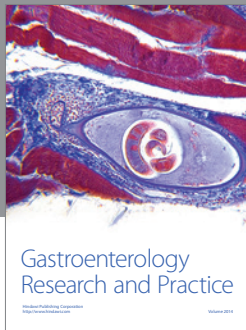
- It should no longer be necessary to use dedicated endoscopes, to place high risk patients at the end of the day's list, or to perform endoscopic procedures in the patient's hospital room.
- Protective masks, glasses or goggles, gowns, aprons and double gloves are necessary in known high risk situations.
- Endoscopist expertise should be acquired during a recognized training period and documented for each procedure: gastroscopy, endoscopic retrograde cholangiopancreatography and colonoscopy.
- Each trainee should keep a record of his/her training certified by the teacher (program director) for accreditation by the Credentials Committee of each hospital.
- Inherent in this record-keeping is a minimum number of procedures to achieve competency and a minimum number per year to maintain competence (4-6). For gastroscopy, this is suggested to be 50 per year; for colonoscopy, 50 per year; and for endoscopic retrograde cholangiopancreatography, 35 per year.

- Quality of care can be readily assessed in endoscopic units, which should be subject to annual audit and review. In this way, a high standard of patient care can be achieved, maintained and seen by all to be in place and working satisfactorily.

Some recommendations may be controversial. If so, please send your comments and suggestions to the Editors.

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